The Honorable Lauren King

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

STATE OF WASHINGTON, et al.,

Plaintiffs,

v.

DONALD J. TRUMP, et al.,

Defendants.

Case No. 2:25-cv-00244

[PROPOSED] BRIEF OF AMICI CURIAE BY AMERICAN ACADEMY OF PEDIATRICS AND ADDITIONAL NATIONAL AND STATE MEDICAL AND MENTAL HEALTH ORGANIZATIONS

NOTE ON MOTION CALENDAR:
February 25, 2025

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INTRODUCTION

On January 28, 2025, President Donald Trump signed Executive Order No. 14187 (the "Healthcare Ban"), directing all federal agencies to "immediately take appropriate steps to ensure that institutions receiving Federal research or education grants end" gender-affirming medical care for people under nineteen, which as this brief describes is critical, medically necessary, evidence-based care for gender dysphoria.[1] Effectively denying such evidence-based medical care to adolescents who meet the requisite medical criteria puts them at risk of significant harm. Below, *amici* provide the Court with an accurate description of the relevant treatment guidelines and summarize the scientific evidence supporting the gender-affirming medical care for adolescents that is targeted in the Healthcare Ban.

Gender dysphoria is a condition that is characterized by clinically significant distress or impairment in social, occupational, or other important areas of functioning due to a marked incongruence between the patient's gender identity (i.e., the innate sense of oneself as being a particular gender) and sex assigned at birth. *See* Jason Rafferty, *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, 142(4) Pediatrics e20182162, at 2–3 tbl.1 (2018), https://perma.cc/DB5G-PG44 ("AAP Policy Statement"). If not treated, or treated improperly, gender dysphoria can result in debilitating anxiety, depression, and self-harm, and is associated with suicidality. As such, the effective treatment of gender dysphoria saves lives.

The medical community, including the respected professional organizations participating here as *amici*, widely recognizes that the appropriate protocol for treating gender dysphoria in

[1] In this brief, the term "gender-affirming medical care" refers to the use of gonadotropin-releasing hormone (GnRH) analogues and/or hormone therapy to treat gender dysphoria. Because this brief focuses primarily on adolescents, it does not discuss surgeries that are typically available to transgender adults, nor does it discuss the treatment guidelines for gender dysphoria in transgender adults affected by the Healthcare Ban.

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transgender adolescents is "gender-affirming care." *Id*. at 10. Gender-affirming care is care that supports an individual with gender dysphoria as they explore their gender identity—in contrast with efforts to change the individual's gender identity to match their sex assigned at birth, which are known to be ineffective and harmful. *See* Christy Mallory et al., *Conversion Therapy and LGBT Youth*, Williams Inst. (June 2019), https://perma.cc/HXY3-UX2J. For adolescents with persistent gender dysphoria that worsens with the onset of puberty, gender-affirming care may include medical care to align their physiology with their gender identity. Empirical evidence indicates that gender-affirming care, including the prescription of puberty blockers and hormone therapy to carefully evaluated patients who meet diagnostic criteria, can alleviate clinically significant distress and lead to significant improvements in the mental health and overall wellbeing of adolescents with gender dysphoria. *See* Simona Martin et al., *Criminalization of Gender-Affirming Care—Interfering with Essential Treatment for Transgender Children and Adolescents*, 385 New Eng. J. Med. 579, at 2 (2021), https://perma.cc/BR4F-YLZS.

The Healthcare Ban disregards this medical evidence by effectively denying adolescents' access to treatments for gender dysphoria in accordance with the well-accepted protocol. Accordingly, *amici* urge this Court to grant Plaintiffs' motion for a preliminary injunction.

ARGUMENT

This brief first provides background on gender identity and gender dysphoria. It then describes the professionally accepted medical guidelines for treating gender dysphoria as they apply to adolescents, the scientifically rigorous process by which these guidelines were developed, and the evidence that supports the effectiveness of this care for adolescents with gender dysphoria. Finally, the brief corrects inaccuracies regarding the professionally accepted medical guidelines for treating gender dysphoria and explains how the Healthcare Ban would irreparably harm adolescents with gender dysphoria by effectively denying access to crucial care for those who need it.

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I. Understanding Gender Identity and Gender Dysphoria.

Gender identity refers to a person's deep internal sense of belonging to a particular gender. AAP Policy Statement at 2 tbl.1. Most people are "cisgender," meaning they have a gender identity that aligns with their sex assigned at birth. Am. Psych. Ass'n, *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People*, 70(9) AMERICAN PSYCHOLOGIST 832, 861–862 (2015), https://www.apa.org/practice/guidelines/transgender.pdf. However, transgender people have a gender identity that does not align with their sex assigned at birth. *Id.* at 863. In the United States, approximately 1.6 million individuals identify as transgender. Jody L. Herman et al., *How Many Adults and Youth Identify as Transgender in the United States?*, Williams Inst., at 2 (June 2022), https://williamsinstitute.law.ucla.edu/wp-content/uploads/Trans-Pop-Update-Jun-2022.pdf. Of these individuals, approximately 10% are teenagers aged 13 to 17. *Id.* at 3. Individuals often start to understand their gender identity during prepubertal childhood and adolescence.

Today, there is an increasing acceptance of being transgender as a normal variation of human identity. James L. Madara, *AMA to States: Stop Interfering in Healthcare of Transgender Children*, Am. Med. Ass'n (Apr. 26, 2021), https://www.ama-assn.org/press-center/press-releases/ama-states-stop-interfering-health-care-transgender-children; Am. Psych. Ass'n, *APA Resolution on Gender Identity Change Efforts*, 4 (Feb. 2021), https://www.apa.org/about/policy/resolution-gender-identity-change-efforts.pdf. However, many transgender people suffer from gender dysphoria, a serious medical condition in which the patient experiences significant distress that can lead to "impairment in peer and/or family relationships, school performance, or other aspects of their life." AAP Policy Statement at 5. Gender dysphoria is a formal diagnosis under the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-5-TR). Am. Psychiatric Ass'n, *Diagnostic and Statistical Manual of Mental*

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Disorders: DSM-5-TR at 512–13 (2022); *see also* World Health Org., International Classification of Diseases, Eleventh Revision (ICD-11) (2019/2021) ("Gender incongruence is characterised by a marked and persistent incongruence between an individual's experienced gender and the assigned sex. Gender variant behaviour and preferences alone are not a basis for assigning the diagnoses in this group.").

If untreated or inadequately treated, gender dysphoria may lead to depression, anxiety, self-harm, and suicidality. *See* Brayden N. Kameg & Donna G. Nativio, *Gender Dysphoria In Youth: An Overview For Primary Care Providers*, 30(9) J. AM. ASS'N NURSE PRAC. 493 (2018), https://pubmed.ncbi.nlm.nih.gov/30095668. In contrast, with treatment, transgender adolescents with gender dysphoria can mature into thriving adults. *See infra* Section II.C.

II. The Widely Accepted Guidelines for Treating Adolescents with Gender Dysphoria Provide for Gender-Affirming Medical Care When Indicated.

The widely accepted view of the professional medical community is that gender-affirming care is the appropriate treatment for gender dysphoria and that, for some adolescents, puberty blockers and hormone therapy are necessary. *See, e.g.*, Endocrine Soc'y, *Transgender Health: An Endocrine Society Position Statement* (2020), https://www.endocrine.org/advocacy/position-statements/transgender-health. Gender-affirming care greatly reduces the negative physical and mental health consequences that result when gender dysphoria is untreated. *See id.*

A. The Gender Dysphoria Treatment Guidelines Include Thorough Mental Health Assessments and, for Some Adolescents, Gender-Affirming Medical Care.

The treatment protocols for gender dysphoria are laid out in established, evidence-based clinical guidelines: (i) the Endocrine Society Clinical Practice Guideline for Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons, and (ii) the WPATH Standards of Care for the Health of Transgender and Gender Diverse People (together, the "Guidelines"). *See* Wylie C.

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Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons*, 102(11) J. CLINICAL ENDOCRINOLOGY & METABOLISM 3869 (Nov. 2017) ("ES Guidelines"), https://academic.oup.com/jcem/article/102/11/3869/4157558; WPATH, *Standards of Care for the Health of Transgender and Gender Diverse People* (8thVersion) ("WPATH Guidelines"), https://www.tandfonline.com/doi/pdf/10.1080/26895269.2022.2100644. The Guidelines have been developed by expert clinicians and researchers who have worked with patients with gender dysphoria for many years.

The Guidelines provide that all youth with gender dysphoria should be evaluated, diagnosed, and treated by a qualified health care professional ("HCP"). Further, the Guidelines provide that each patient who receives gender-affirming care should receive only medically necessary and appropriate care that is tailored to the patient's individual needs and that is based on the best evidence possible along with clinical experience. WPATH Guidelines at S16–S18; ES Guidelines at 3872–73.

1. The Guidelines Do Not Recommend Gender-Affirming Medical Care for Prepubertal Children.

For prepubertal children with gender dysphoria, the Guidelines provide for mental health care and support for the child and their family, such as through psychotherapy and social transitioning. WPATH Guidelines at S73–S74; ES Guidelines at 3877–78. ("Social transition" refers to a process by which a child is acknowledged by others and has the opportunity to live publicly, either in all situations or in certain situations, in the gender identity they affirm. WPATH Guidelines at S75.) The Guidelines do *not* recommend that prepubertal children with gender dysphoria receive puberty blockers, hormone therapy, or surgeries. WPATH Guidelines at S64, S67; ES Guidelines at 3871.

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2. A Robust Diagnostic Assessment Is Required Before Gender-Affirming Medical Care Is Provided.

In contrast to prepubertal children, the Guidelines do contemplate the possibility that, for some transgender adolescents with gender dysphoria, gender-affirming medical care may be indicated, provided certain criteria are met. According to the Guidelines, puberty blockers and hormone therapy should be provided only after a thorough evaluation by a qualified HCP who: is licensed by their statutory body and holds a master's degree or equivalent in a relevant clinical field; has expertise and received theoretical and evidence-based training in child, adolescent, and family mental health; has expertise and received training in gender identity development, gender diversity in children and adolescents, has the ability to assess capacity to consent, and possesses knowledge about gender diversity across the life span; has expertise and received training in autism spectrum disorders and other neurodevelopmental presentations, or collaborates with a developmental disability expert when working with neurodivergent patients; and continues engagement in professional development in areas relevant to gender diverse children, adolescents, and families. WPATH Guidelines at S49.

Prior to developing a treatment plan, the HCP should conduct a robust diagnostic assessment—specifically, a "comprehensive biopsychosocial assessment"—of the adolescent patient. *Id.* at S50. The HCP conducts this assessment to "understand the adolescent's strengths, vulnerabilities, diagnostic profile, and unique needs," so that the resulting treatment plan is appropriately individualized. *Id.* This assessment must be conducted collaboratively with the patient and their caregiver(s). *Id.*

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3. In Certain Circumstances, the Guidelines Provide for the Use of Gender-Affirming Medical Care to Treat Adolescents With Gender Dysphoria.

For youth with gender dysphoria that continues into adolescence—after the onset of puberty—the Guidelines provide that, in addition to mental health care, gender-affirming medical care may be indicated. Before an adolescent may receive any gender-affirming medical care for treating gender dysphoria, a qualified HCP must make a determination that such medical care is indicated. The Guidelines collectively provide that, before prescribing puberty blockers, the HCP must determine that: (1) the adolescent meets the diagnostic criteria of gender dysphoria or gender incongruence according to an established taxonomy; ES Guidelines at 3876; WPATH Guidelines at S47, S48; (2) the adolescent has demonstrated a sustained and persistent pattern of gender nonconformity or gender dysphoria; (3) the adolescent has demonstrated the emotional and cognitive maturity required to provide informed consent for treatment; (4) any coexisting psychological, medical, or social problems that could interfere with diagnosis, treatment, or the adolescent's ability to consent have been addressed; (5) the adolescent has been informed of the reproductive effects of treatment in the context of their stage in pubertal development and discussed fertility preservation options; and (6) the adolescent has reached Tanner stage 2 of puberty to initiate pubertal suppression. WPATH Guidelines at S59–65. Further, a pediatric endocrinologist or other clinician experienced in pubertal assessment must (7) agree with the indication for treatment, (8) confirm the patient has started puberty, and (9) confirm that there are no medical contraindications. ES Guidelines at 3878 tbl.5.

If all the above criteria are met, and the patient and their parents provide informed consent, gonadotropin-releasing hormone (GnRH) analogues, or "puberty blockers," may be offered beginning at the onset of puberty. WPATH Guidelines at S61–62, S64; ES Guidelines at 3878 tbl.5; Simona Martin et al., *Criminalization of Gender-Affirming Care—Interfering with Essential*

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Treatment for Transgender Children and Adolescents, 385 New Eng. J. Med. 579, at 2 (2021), https://perma.cc/BR4F-YLZS. The purpose of puberty blockers is to delay the development of permanent secondary sex characteristics—which may result in significant distress for transgender youth—until adolescents are old enough and have had sufficient time to make more informed decisions about whether to pursue further treatments. WPATH Guidelines at S112. Puberty blockers also can make pursuing transition later in life easier, because they prevent irreversible bodily changes such as protrusion of the Adam's apple or breast growth. *See* AAP Policy Statement at 5. Puberty blockers have well-known efficacy and side-effect profiles. *See* Martin, 385 New Eng. J. Med. 579, at 2. Their effects are generally reversible, and when a patient discontinues their use, the patient resumes endogenous puberty. *See id.* In fact, puberty blockers have been used by pediatric endocrinologists for more than 40 years for the treatment of precocious puberty. *See* F. Comite et al., *Short-Term Treatment of Idiopathic Precocious Puberty with a Long-Acting Analogue of Luteinizing Hormone-Releasing Hormone — A Preliminary Report*, 305 NEJM 1546 (1981). The risks of any serious adverse effects from puberty blockers are exceedingly rare when provided under clinical supervision. *See, e.g.*, Annemieke S. Staphorsius et al., *Puberty Suppression and Executive Functioning*, 6 PSCYHONEUROENDOCRINOLOGY 190 (2015), https://pubmed.ncbi. nlm.nih.gov/25837854 (no adverse impact on executive functioning); Ken C. Pang et al., *Long-term Puberty Suppression for a Nonbinary Teenager*, 145(2) PEDIATRICS e20191606 (2019), https://watermark.silverchair.com/peds_20191606.pdf (exceedingly low risk of delayed bone mineralization from hormone treatment).

Later in adolescence—and if the criteria below are met—hormone therapy may be used to initiate puberty consistent with the patient's gender identity. *See* Martin, 385 New Eng. J. Med. 579, at 2. Hormone therapy involves using gender-affirming hormones to allow adolescents to develop secondary sex characteristics consistent with their gender identity. *See* AAP Policy

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Statement at 6. Hormone therapy is only prescribed when a qualified HCP has confirmed the persistence of the patient's gender dysphoria, the patient's mental capacity to consent to the treatment, and that any coexisting problems have been addressed. Endocrine Soc'y Guidelines at 3878 tbl.5. A pediatric endocrinologist or other clinician experienced in pubertal induction must also agree with the indication, and the patient and their parents must be informed of the potential effects and side effects and give their informed consent. *See id*. Although some of the changes caused by hormone therapy become irreversible after those secondary sex characteristics are fully developed, others are partially reversible if the patient discontinues use of the hormones. *See* AAP Policy Statement at 5–6.

The Guidelines contemplate that the prescription of puberty blockers and/or hormone therapy be coupled with education on the safe use of such medications and close monitoring to mitigate any potential risks. *See* Endocrine Soc'y Guidelines at 3871, 3876. Decisions regarding the appropriate treatment for each patient with gender dysphoria are made in consultation with the patient, their parents, and the medical and mental health care team. There is "no one-size-fits-all approach to this kind of care." Martin, 385 New Eng. J. Med. 579, at 1.

B. The Guidelines for Treating Gender Dysphoria Were Developed Through a Robust and Transparent Process, Employing the Same Scientific Rigor That Underpins Other Medical Guidelines.

The Guidelines are the product of careful and robust deliberation following the same types of processes—and subject to the same types of rigorous requirements—as other guidelines promulgated by *amici* and other medical organizations with respect to other areas of medicine, such as treatments for cancer, diabetes, or cardiovascular disease.

For example, the Endocrine Society Guidelines were developed following a 26-step, 26-month drafting, comment, and review process. *See, e.g.*, Endocrine Soc'y Guidelines at 3872–73. The Endocrine Society imposed strict evidentiary requirements based on the internationally

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recognized Grading of Recommendations Assessment, Development and Evaluation (GRADE) system. *See* Gordon Guyatt et al., *GRADE Guidelines: 1. Introduction - GRADE Evidence Profiles and Summary of Findings Tables*, 64 J. CLINICAL EPIDEMIOLOGY 383 (2011), https://perma.cc/RE29-ZT37. That GRADE assessment was then reviewed, re-reviewed, and reviewed again by independent groups of professionals. Endocrine Soc'y, *Methodology*, https://www.endocrine.org/clinical-practice-guidelines/methodology. Reviewers were subject to strict conflict of interest rules, and there was ample opportunity for feedback and debate through the years-long review process. *See id*. Further, the Endocrine Society continually reviews its own guidelines and recently determined that the 2017 transgender care guidelines continue to reflect the best, most up-to-date available evidence. *See* Endocrine Soc'y, Endocrine Soc'y Statement in Support of Gender-Affirming Care (May 8, 2024), https://perma.cc/J4Y2-RUJ2.

First published in 1979, the WPATH Standards of Care are currently in their 8th Edition. The current Standards of Care are the result of a robust drafting, comment, and review process that collectively took five years. *See* WPATH Guidelines at S247-51. The draft guidelines went through rigorous review and were publicly available for discussion and debate, receiving a total of 2,688 comments. *See id*. There were 119 authors ultimately involved in the final draft, including feedback from experts in the field as well as from transgender individuals and their families. *See id.* Inclusion of input from the relevant patient population during development of medical guidelines adheres to national standards and best practices. *See* National Academy of Sciences, *Clinical Practice Guidelines We Can Trust* at 89–92 (2011), https://perma.cc/Q479-TGW3. Each recommendation in the Standards of Care was formally approved using the Delphi process, *see* WPATH Guidelines at S247-51, which is one of the most commonly adopted consensus development strategies for medical clinical practice guidelines, *see* National Academy of Sciences, *Clinical Practice Guidelines We Can Trust* at 88 (2011).

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C. Scientific Evidence Indicates the Effectiveness of Treating Gender Dysphoria According to the Guidelines.

Multiple studies indicate that adolescents with gender dysphoria who receive gender-affirming medical care experience improvements in their overall well-being. These studies find positive mental health outcomes for those adolescents who received puberty blockers or hormone therapy, including statistically significant reductions in anxiety, depression, and suicidal ideation.

For example, a longitudinal study of nearly 50 transgender adolescents found that suicidality was decreased by a statistically significant degree after receiving gender-affirming hormone treatment. Luke R. Allen et al., *Well-Being and Suicidality Among Transgender Youth After Gender-Affirming Hormones*, 7(3) CLINICAL PRAC. PEDIATRIC PSYCH. 302 (2019), https://psycnet.apa.org/record/2019-52280-009. A study published in January 2023, following 315 participants ages 12 to 20 who received gender-affirming hormone treatment, found that the treatment was associated with decreased symptoms of depression and anxiety. Diane Chen et al., *Psychosocial Functioning in Transgender Youth after 2 Years of Hormones*, 388(3) NEJM 240–250 (2023). Additionally, a 2020 study analyzed survey data from 89 transgender adults who had access to puberty blockers while adolescents and from more than 3,400 transgender adults who did not. Jack L. Turban et al., *Access To Gender-Affirming Hormones During Adolescence and Mental Health Outcomes Among Transgender Adults*, J. PLOS ONE (2022), https://perma.cc/4VEK-7M8N. The study found that those who received puberty blocking treatment had lower odds of lifetime suicidal ideation than those who wanted puberty blocking treatment but did not receive it, even after adjusting for demographic variables and level of family support. *Id*. Approximately *nine in ten* transgender adults who wanted puberty blocking treatment but did not receive it reported lifetime suicidal ideation. *Id.*

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Further, a prospective two-year follow-up study of adolescents with gender dysphoria published in 2011 found that treatment with puberty blockers was associated with decreased depression and improved overall functioning. Annelou L.C. de Vries et al., *Puberty Suppression In Adolescents With Gender Identity Disorder*, 8(8) J. SEXUAL MED. 2276–2283 (2011), https://pubmed.ncbi.nlm. nih.gov/ 20646177. A six-year follow-up study of 55 individuals from the 2011 study found that subsequent treatment with hormone therapy followed by surgery in adulthood was associated with a statistically significant decrease in depression and anxiety. Annelou L.C. de Vries et al., *Young Adult Psychological Outcome After Puberty Suppression And Gender Reassignment*, 134(4) PEDIATRICS 696–704 (2014), https://pubmed.ncbi.nlm.nih.gov/25201798. "Remarkably, this study demonstrated that these transgender adolescents and young adults had a sense of well-being that was equivalent or superior to that seen in age-matched controls from the general population." Stephen M. Rosenthal, *Challenges in the Care of Transgender and Gender-Diverse Youth: An Endocrinologist's View*, 17(10) NATURE REV. ENDOCRINOLOGY 581, 586 (Oct. 2021), https://pubmed.ncbi.nlm.nih.gov/34376826.

As clinicians and scientific researchers, *amici* always welcome more research, including on this crucial topic. However, the available data indicate that the gender-affirming medical care targeted in the Healthcare Ban is effective for the treatment of gender dysphoria.

III. The Healthcare Ban Relies on Factually Inaccurate Claims and Ignores the Recommendations of the Medical Community.

In attempting to justify effectively denying access to gender-affirming medical care, the Healthcare Ban makes claims which are factually incorrect and contradicted by the available scientific evidence. In particular, the Healthcare Ban states that "[c]ountless children soon regret" receiving gender-affirming medical care. Exec. Order No. 14187 § 1. The Healthcare Ban

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improperly conflates prepubertal children with adolescents, which is an important distinction, as prepubertal children are not eligible under the Guidelines for any of the gender-affirming medical care targeted in the Healthcare Ban. *See* Susan D. Boulware et al., *Biased Science: The Texas and Alabama Measures Criminalizing Medical Treatment for Transgender Children and Adolescents Rely on Inaccurate and Misleading Scientific Claims*, 1, 18 (Apr. 28, 2022), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4102374. The Guidelines endorse the use of this medical care only to treat adolescents and adults with gender dysphoria, and only when the relevant criteria are met. *See* Endocrine Soc'y Guidelines at 3871, 3879; WPATH Guidelines at S32, S48.

There are *no* studies to support the proposition that adolescents with gender dysphoria are likely to later identify as their sex assigned at birth, whether they receive treatment or not. *See, e.g.*, Stewart L. Adelson, *Practice Parameter on Gay, Lesbian, or Bisexual Sexual Orientation, Gender Non-Conformity, and Gender Discordance in Children and Adolescents*, 51 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 957, 964 (2020), https://pubmed.ncbi.nlm.nih.gov/22917211. On the contrary, "[l]ongitudinal studies have indicated that the emergence or worsening of gender dysphoria with pubertal onset is associated with a very high likelihood of being a transgender adult." Rosenthal, NATURE REV. ENDOCRINOLOGY 581, 585.

Moreover, while detransitioning may occur for many reasons, detransitioning is not the same as regret. The Healthcare Ban incorrectly assumes that an individual who detransitions—the definition of which varies from study to study—must do so because they have come to identify with their sex assigned at birth. *See* Michael S. Irwig, *Detransition Among Transgender and Gender-Diverse People—An Increasing and Increasingly Complex Phenomenon*, J. CLINICAL ENDOCRINOLOGY & METABOLISM 1, 1 (June 2022), https:// pubmed.ncbi.nlm.nih.gov/35678284 ("Detransition refers to the stopping or reversal of transitioning which could be social (gender

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presentation, pronouns), medical (hormone therapy), surgical, or legal."). This ignores other, more commonly reported factors that contribute to a person's choice to detransition, such as pressure from parents and discrimination. *See id.* (discussing "largest study to look at detransition").

In addition, while the percentage of adolescents seeking gender-affirming care has increased, that percentage remains very low—only 1.8% of high-school students identify as transgender, *see* Michelle M. Johns et al., *Transgender Identity and Experiences of Violence Victimization, Substance Use, Suicide Risk, and Sexual Risk Behaviors Among High School Students–19 States and Large Urban School Districts, 2017*, HHS/CDC, 68 MORBIDITY & MORTALITY WKLY. REP. 67, 68 (2019), https://www.cdc.gov/mmwr/volumes/68/wr/pdfs/mm6803a3-H.pdf, and only a small fraction of transgender adolescents are prescribed gender-affirming medical care, *see* Landon D. Hughes, Brittany M. Charlton, Isa Berzansky, *Gender-Affirming Medications Among Transgender Adolescents in the US, 2018-2022*, JAMA PEDIATR. (Jan. 6, 2025), https://pubmed.ncbi.nlm.nih.gov/39761053/ (finding that less than 0.1% of transgender adolescents are prescribed puberty blockers or hormone therapy by examining private insurance claims over 5 years). Further, research supports that this increase in adolescents seeking care is very likely the result of reduced social stigma and expanded care options. *See* Boulware, 20.

IV. The Healthcare Ban Would Irreparably Harm Many Adolescents with Gender Dysphoria By Effectively Denying Them Access to the Treatment They Need.

The Healthcare Ban effectively denies adolescents with gender dysphoria throughout the United States access to medical care that is designed to improve health outcomes and alleviate suffering and that is grounded in science and endorsed by the medical community. The gender-affirming medical care targeted in the Healthcare Ban can be a crucial part of treatment for transgender adolescents with gender dysphoria and necessary to preserve their health. Clinicians

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who are members of the relevant *amici* associations have witnessed the benefits of this treatment as well as the harm that results when such treatment is denied or delayed.

As discussed above, research shows that adolescents with gender dysphoria who receive puberty blockers and/or hormone therapy experience less depression, anxiety, and suicidal ideation. Several studies have found that hormone therapy is associated with reductions in the rate of suicide attempts and significant improvement in quality of life. *See* M. Hassan Murad et al., H*ormonal Therapy and Sex Reassignment: A Systematic Review and Meta-Analysis of Quality of Life and Psychosocial Outcomes*, 72(2) CLINICAL ENDOCRINOLOGY 214 (Feb. 2010), https://onlinelibrary.wiley.com/doi/10.1111/j.1365-2265.2009.03625.x; Jack L. Turban et al., *Access To Gender-Affirming Hormones During Adolescence and Mental Health Outcomes Among Transgender Adults*, J. PLOS ONE (2022), https://perma.cc/4VEK-7M8N. In light of this evidence supporting the connection between lack of access to gender-affirming medical care and lifetime suicide risk, banning such care can put patients' lives at risk.

CONCLUSION

For the foregoing reasons, the Court should grant Plaintiffs' motion for a preliminary injunction.

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Respectfully submitted,

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I certify that this unopposed motion for leave to file brief of *amici curiae* contains 4,146 words, in compliance with Local Civil Rules.

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CERTIFICATE OF SERVICE

The undersigned certifies under penalty of perjury under the laws of the State of Washington, that the foregoing document was presented to the Clerk of the Court for filing and uploading to the CM/ECF system, which will send notification of such filing to all counsel of record.

DATED this 25th day of February, 2025.

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